IN THE

Supreme Court of the United States

OCTOBER TERM, 1977

No. 77-952

GROUP LIFE AND HEALTH INSURANCE COMPANY, also known as BLUE SHIELD OF TEXAS, *et al.*,
Petitioners,

v.

ROYAL DRUG COMPANY, INC., doing business as ROYAL PHARMACY OF CASTLE HILLS and DISCO PRESCRIPTION PHARMACY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF FOR PETITIONERS

Petitioners Group Life and Health Insurance Company, Rieger/Medi-Save Pharmacies, Inc., Walgreen Texas Co. and The Sommers Drug Stores Company request this Court to reverse the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States District Court for the Western District of Texas is reported at 415 F. Supp.

343. The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 556 F.2d 1375. The District Court and Court of Appeals opinions are reproduced at pages 100a-115a and 117a-138a of the Appendix ("App.").

JURISDICTION

The judgment of the Court of Appeals was entered on August 8, 1977. (App. 139a) A Petition For Rehearing And Rehearing *En Banc* was denied on October 27, 1977. (App. 140a) A timely Petition For A Writ Of Certiorari was filed on January 3, 1978, and certiorari was granted on February 27, 1978. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

STATUTES INVOLVED

The provisions of the McCarran-Ferguson Act ("McCarran Act") involved in this case, §§ 1-3, 59 Stat. 33 (1945), 15 U.S.C. §§ 1011-1013 (1976), are set forth in the Addendum.[1]

QUESTION PRESENTED

The question presented is whether the "business of insurance," within the meaning of the antitrust exemption afforded by the McCarran Act, includes a contract between an insurer and a health care provider to furnish benefits owed to policyholders under the insurer's health care policies.

STATEMENT OF THE CASE

Petitioner Group Life and Health Insurance Company, also known as Blue Shield of Texas ("Blue Shield"), is

[1] Pertinent provisions of the Texas Insurance Code and antitrust statutes are also incorporated in the Addendum ("Add.").

an insurance company duly authorized by the Texas State Board of Insurance to transact the business of life, health and accident insurance within the State of Texas.[2] (App. 433a, 471a-472a) Petitioners Rieger/Medi-Save Pharmacies, Inc., Walgreen Texas Co. and The Sommers Drug Stores Company (the "pharmacy petitioners") own and operate pharmacies in San Antonio, Texas. (App. 14a, 19a, 31a)

Respondents, plaintiffs below, are eighteen pharmacy owners and operators also doing business in San Antonio. (App. 2a-5a) Respondents' antitrust action for treble damages and injunctive relief challenges certain aspects of Blue Shield's prepaid prescription drug insurance program. Specifically, respondents attack the contracts between Blue Shield and pharmacies under which the pharmacies provide drugs to Blue Shield's insureds and are reimbursed by Blue Shield.

The United States District Court for the Western District of Texas determined that Blue Shield's insurance plan, including the pharmacy contracts, constituted the "business of insurance" and was exempt from the Sherman Act by virtue of the McCarran Act. The United States Court of Appeals for the Fifth Circuit reversed, holding that Blue Shield's pharmacy contracts were not

[2] Blue Shield is a legal reserve stock insurance company organized under Chapter 3 of the Texas Insurance Code, *Tex. Ins. Code Ann.* art. 3.01 *et seq.* (1963). (*See also* Depo. of Donald H. Bunnell ("Bunnell Depo."), App. 423a) [Mr. Bunnell is Manager of the Company License Section of the Texas State Board of Insurance, having responsibility for licensing insurers, authorizing types of coverage and supervising insurers' financial condition. (App. 422a)] All of the stock of Blue Shield, with the exception of a few qualifying shares, is owned by Group Hospital Service, Inc., a non-profit hospitalization insurer organized under Chapter 20 of the Insurance Code, *Tex. Ins. Code Ann.* art. 20.01 *et seq.* (1963). Group Hospital Service, Inc., is also known as Blue Cross of Texas. (Affidavit of Steve G. McDonald ("McDonald Aff."), App. 45a-46a)

the "business of insurance" within the contemplation of the Act.

A. The Challenged Provisions of Blue Shield's Prescription Drug Insurance Program

Blue Shield is in the business, *inter alia*, of selling prepaid prescription drug insurance policies. (App. 7a, 26a) These policies insure the policyholder against the risk of financial loss resulting from the purchase of drugs prescribed by his physician, and the possibility that the insured will be unable to afford such drugs. Prepaid drug policies are issued as part of group health insurance plans whereby Blue Shield (and, in some cases, Texas Blue Cross) insure employee groups for comprehensive health care benefits and employers pay part or all of the policy premiums. (Depo. of Steve G. McDonald ("McDonald Depo."), App. 296a. A copy of Blue Shield's "Drug Supplement Policy" is reproduced at App. 51a-58a.)

The policies in issue obligate Blue Shield to insure its policyholders against the cost of drugs in either of two ways: primarily by contractual arrangements with pharmacies who agree to provide prescription drugs to the insureds in exchange for reimbursement from Blue Shield; and secondarily by partial cash reimbursement to the policyholder for amounts expended in the purchase of drugs. The Participating Drug Pharmacy Agreement ("Pharmacy Agreement") attacked by respondents is the mechanism through which prescription drug benefits are provided to insureds in accordance with Blue Shield's obligations under the policy. (A copy of the Pharmacy Agreement is reproduced at App. 59a-61a.)

Blue Shield's insureds are entitled to obtain prescription drugs from any pharmacy they choose. (App. 166a) If the pharmacy selected has entered into a Pharmacy Agreement with Blue Shield (a "Participating Pharmacy"), the policy provides that the insured is required to pay no more than a $2.00 deductible for each prescription.[3] (App. 55a) The availability of Participating Pharmacies which agree not to charge the insured in excess of $2.00 is thus a benefit under the policies. Under the Pharmacy Agreement, a Participating Pharmacy agrees to dispense drugs to Blue Shield's insureds and to accept no more than $2.00 (the deductible) as full payment from the insured for each dispensed drug. (App. 60a, 175a) The Participating Pharmacy is then entitled to file a claim for additional reimbursement directly from Blue Shield. (App. 60a, 182a) Blue Shield agrees to reimburse the Participating Pharmacy for the acquisition cost of each dispensed drug, plus a dispensing fee of $2.00, minus the amount of the deductible.[4] (App. 60a, 175a) If the insured's prescription is filled by a pharmacy other than a Participating Pharmacy, the policy provides that Blue Shield will reimburse the insured for 75 percent of the "usual and customary charge" for the drug, after first subtracting the $2.00 deductible.[5] (App. 56a, 170a, 184a)

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[3] Participating Pharmacies are designated as "Participating Providers" in the policies, and are defined as those who "[have] entered into a written contract [with Blue Shield] for the rendition of covered drugs for which benefits are provided by this [policy] . . . ." (App. 54a)

[4] The total amount received by the pharmacy therefore is equal to the acquisition cost (received from Blue Shield) plus $2.00 (received from the insured). In 1974, Texas Blue Shield paid $1,145,342.22 in claims on a total of 308,128 prescriptions. Thus, the average prescription claim payment by Blue Shield was $3.72, in addition to which Participating Pharmacies received $2.00 per claim from the policyholder. (Depo. of Judith M. Johnson ("Johnson Depo."), "Out-of-Hospital Prescription Drugs Questionnaire" dated March 12, 1975, unnumbered Exhibit)

[5] The administrative costs of processing claims for drugs purchased from non-participating pharmacies are higher than for those purchased from participating pharmacies. In the former case, the insured typically sends in only a receipt for the prescription,

The opportunity of entering into a Pharmacy Agreement has always been available to all licensed pharmacies in Texas, including each of the respondents. (McDonald Aff., App. 48a; Johnson Depo., App. 151a-152a) Indeed, nine of the respondents operate Participating Pharmacies in the San Antonio area, as do the pharmacy petitioners. (App. 14a, 19a, 31a; McDonald Aff., App. 50a)

B. The History of the Drug Insurance Program

The insurance program here in issue had its origins in 1967, when the United Auto Workers and the three largest domestic automobile manufacturers entered into a collective bargaining agreement establishing a prepaid prescription drug program for U.A.W. members to become effective October 1, 1969. (McDonald Depo., App. 301a. A memorandum describing the U.A.W. plan is reproduced at App. 205a-275a.) The labor-management agreement explicitly required participating pharmacies to be used. (App. 205a) Michigan Blue Shield was the first insurer to offer the program (App. 242a, 245a, 249a), and Blue Shield of Texas subsequently agreed to provide the coverage for employees of Ford Motor Company and Chrysler Corporation living in Texas. (McDonald Depo., App. 296a-297a; Johnson Depo., App. 143a-144a)

In order to implement the program as required in the collective bargaining agreement, Blue Shield drafted a policy form and Pharmacy Agreement. In March, 1969,

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which does not contain sufficient information to process the claim. Thereafter, Blue Shield must correspond with the insured to obtain the additional information necessary to prepare a proper claim form. In addition, unlike claims information submitted by participating pharmacies, information received from insureds is not coded on special forms so as to allow direct input into Blue Shield's computers. The amount of work necessary to enter such information in data processing equipment is thus increased if an insured's prescription is filled by a non-participating pharmacy. (Depo. of Lee Helis ("Helis Depo."), App. 283a-284a)

in compliance with the requirements of Article 3.42 of the Texas Insurance Code, *Tex. Ins. Code Ann.* art. 3.42 (Supp. 1977) (Add. 2a-4a),[6] Blue Shield filed the proposed policy and the annexed Pharmacy Agreement with the Texas State Board of Insurance ("State Board") for approval. (App. 352a-353a; McDonald Depo., App. 297a) In June, 1969, the State Board issued an order disapproving the proposed policy and Pharmacy Agreement. (App. 365a-366a) While the disapproval order was in effect, Blue Shield did not issue or use either the policy or the Pharmacy Agreement. (McDonald Aff., App. 47a)

Following disapproval, however, the policy and Pharmacy Agreement remained under consideration by the State Board. (Depo. of Paul Connor ("Connor Depo."), App. 392a-393a)[7] In September, 1969, the Board issued another order, this time *authorizing* the issuance and use of the policy and the Pharmacy Agreement. (App. 370a-371a)[8] In pertinent part, the order provided that, effective upon issuance, the policy would:

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[6] Article 3.42 of the Code is a typical "prior approval" form of insurance regulation. It requires all life, health and accident insurers to file proposed policy forms with the Texas State Board of Insurance for approval prior to issuance or use by the company.

[7] Mr. Connor was employed by the State Board for twenty-three years. During the first ten years of his employment, he was General Counsel to the Board. During the remaining thirteen years he held the position of Deputy Commissioner of Insurance. (App. 388a-389a)

[8] The order was entered under Article 3.42(e) of the Insurance Code, *Tex. Ins. Code Ann.* art. 3.42(e) (Supp. 1977), which grants authority to the State Board to exempt "any insurance document or form" from the approval requirements of Article 3.42 when deemed it proper. (Add. 3a-4a) The order authorized Blue Shield to issue and use the policy in the State of Texas in the same manner as if an approval order had been entered. (Connor Depo., App. 401a; Depo. of A. W. Pogue ("Pogue Depo."), App. 332a; Depo. of R. C. McAnelly ("McAnelly Depo."), App. 417a) [Mr. Pogue is Manager of the Policy Approval Division of the State Board of Insurance, whose duties include approval of proposed policies filed under the pro-

> confer upon the policyholder the right to obtain certain prescribed drugs at a cost fixed in the contract, the *insurer having entered into participating agreements with dispensing pharmacies to supply the prescribed drugs to its policyholders.* [(App. 371a) (emphasis added)]

The policy and Agreement were authorized in part for the purpose of permitting Blue Shield to implement the provisions of the 1967 U.A.W. collective bargaining agreement. (Connor Depo., App. 392a-393a) The order remains in full force and effect. (Pogue Depo., App. 346a; McDonald Aff., App. 49a)

Upon receipt of the order authorizing use of the policy, Blue Shield sent a standard form letter to all licensed pharmacies in the State offering them the opportunity to enter into a Pharmacy Agreement. (McDonald Aff., App. 48a; Johnson Depo., App. 147a) The formula pursuant to which Blue Shield offered to reimburse the Participating Pharmacies (*i.e.*, the acquisition cost of the drug, plus the $2.00 dispensing fee, minus the deductible) was determined in accordance with the collective bargaining agreement between the U.A.W. and the automobile manufacturers. (App. 211a-212a) There were no negotiations with or among the pharmacies. (App. 95a-96a, 98a-99a) Thereafter, Blue Shield issued the policy

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visions of Article 3.42. (App. 320a-322a, 324a-325a) Mr. McAnelly was head of the unit which had specific authority for approval of accident and health insurance policies. (App. 410a)] An exemption is therefore equivalent to an approval (Pogue Depo., App. 333a-334a; McAnelly Depo., App. 417a), and exempts the policy from nothing more than the requirement of formal approval by the State Board. (McAnelly Depo., App. 415a) Like approved policies, exempt policies are subject to all requirements of the Texas Insurance Code and to all aspects of the State Board's continuing regulation, control and supervision. (Connor Depo., App. 394a-395a; Pogue Depo., App. 332a-333a; McAnelly Depo., App. 416a, 419a) Indeed, "the degree of regulation may be a little greater with the exempt policy . . . ." (Connor Depo., App. 395a)

to various groups (McDonald Aff., App. 48a) and, in order to be able to provide the policy benefits, entered into the Pharmacy Agreement with pharmacies throughout Texas.

In 1974, Blue Shield decided to offer a comprehensive medical care plan, including prepaid prescription drug coverage, to various groups in the San Antonio metropolitan area. (McDonald Aff., App. 48a) In September, 1974, pursuant to Article 3.42 of the Insurance Code, a policy form identical to the one submitted in 1969 was filed with the State Board for approval prior to issuance. (App. 76a-77a; McDonald Aff., App. 49a) In October, 1974, the Commissioner issued an order approving use of the policy. (App. 385a-386a) After receipt of that approval order, Blue Shield issued the policy to various groups and, through another mass mailing, again offered the opportunity of entering into a Pharmacy Agreement to all licensed pharmacies in San Antonio. (McDonald Aff., App. 49a; App. 194a-195a)

C. The Complaint and the Decisions Below

Respondents brought suit in May, 1975 (App. 1a), alleging that the Pharmacy Agreements between Blue Shield and the pharmacy petitioners constituted a conspiracy to fix retail drug prices and to cause Blue Shield's insureds to refuse to deal with non-participating pharmacies in violation of § 1 of the Sherman Act, 15 U.S.C. § 1 (Supp. 1975). (App. 7a-8a) Respondents admitted in their complaint that in selling prepaid prescription drug insurance Blue Shield was engaged in the "business of insurance." (App. 7a) They contended, however, that in contracting with pharmacies to provide policy benefits to its insureds, Blue Shield was not engaged in the "business of insurance" within the meaning of the McCarran Act. (App. 106a) The proceedings in the District Court

focused on petitioners' defense that the McCarran Act barred the relief sought.

Upon the conclusion of extensive discovery regarding the "business of insurance" and other McCarran Act issues (App. 101a-102a), all parties agreed to submit the exemption defense for determination by the court. (App. 34a-37a) The District Court subsequently ordered suspension of all further discovery in order that the appropriate motions might be filed. (App. 38a-41a)

Petitioners' motions to dismiss for failure to state a claim were granted on the ground that both the policies and the Pharmacy Agreement were immunized from the Sherman Act by the McCarran Act.[9] Relying upon this Court's decision in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453 (1969), the District Court determined that the policies and the Pharmacy Agreement were part of the "business of insurance", were regulated by Texas law under both the Texas Insurance Code and the State's antitrust statutes, and did not constitute a "boycott" within the meaning of the McCarran Act.

In deciding whether the Pharmacy Agreement was within the scope of the "business of insurance," the court found that the Agreement was based upon the coverage and benefits provisions of the policies; was simply the performance of Blue Shield's obligations owed to its insureds; and thus directly concerned the interpretation

[9] Each petitioner had separately moved to dismiss the complaint pursuant to Rule 12(b)(6), Fed. R. Civ. P., or for summary judgment under Rule 56. (App. 42a-44a, 81a-83a, 84a-85a, 86a-88a) The Court treated the motions as requests for summary judgment. (App. 115a) The applicability of the McCarran Act exemption was the only issue presented to and decided by the District Court. (App. 42a-44a, 81a-83a, 84a-85a, 86a-88a, 101a) Upon its dismissal of respondents' Sherman Act claims, the court also dismissed pendent claims, filed under the Texas antitrust laws, for lack of subject matter jurisdiction. (App. 114a)

and enforcement of the policies. (App. 107a) For these reasons, the District Court concluded that "the method adopted by Blue Shield of providing benefits under the [p]olicies is closely connected to the relationship between Blue Shield and its insureds." (App. 107a) Finally, the District Court held that by virtue of their contractual agreements with Blue Shield, the pharmacy petitioners had become "an integral part of the overall scheme of insurance coverage which is regulated by state law." (App. 113a) Consequently, the court found that to this extent they were engaged in the "business of insurance" and were also entitled to the protection afforded by the Act.

The Court of Appeals reversed, holding that the Pharmacy Agreement did not pertain to the relationship between Blue Shield and its insureds. Rejecting the District Court's factual findings that the Pharmacy Agreement was inseparable from the policy provisions relating to benefits and coverage, the court concluded that "Blue Shield's policyholders are basically unconcerned with the contract between the insurer and the Participating Pharmacy." [10] (App. 126a) As a result, the Court of Appeals held that the Pharmacy Agreement did not constitute the "business of insurance" for McCarran Act purposes.[11]

[10] The Court of Appeals repeatedly characterized Blue Shield's prescription drug policies and Pharmacy Agreements as "price-fixing" despite the fact that no evidence had been presented in the lower court or even any discovery undertaken on that issue. (App. 126a, 127a, 132a, 138a) Since the summary judgment did not reach the issue of price-fixing, the Court of Appeals exceeded its authority in purporting to address that issue. Fountain v. Filson, 336 U.S. 681 (1949). Were this Court to affirm the court below on the "business of insurance" issue, the case should be remanded to the District Court for discovery and trial on the merits of respondents' antitrust claims.

[11] Because its decision on the "business of insurance" issue was dispositive, the Court of Appeals found it unnecessary to reach the state regulation and boycott questions which the District Court had decided adversely to respondents. (App. 108a-112a)

SUMMARY OF ARGUMENT

The McCarran Act was designed to entrust regulation of insurance exclusively to the states by exempting the "business of insurance" from the Sherman, Clayton and Federal Trade Commission Acts to the extent that such business and any "person engaged therein" are "regulated by State law" and have not engaged in any act or agreement of "boycott, coercion and intimidation." 15 U.S.C. §§ 1011-1013 (1976). This immunity from federal antitrust scrutiny embraces the conduct challenged by respondents.

Drawing from the intent of the authors of the Act and from prior decisions, this Court in *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453, 460 (1969), defined the "business of insurance" as centering upon "the relationship between insurer and insured." Specifically, (1) "the type of policy which could be issued," (2) "its reliability, interpretation and enforcement," and (3) "other activities of insurance companies [which] relate . . . closely to their status as reliable insurers" were described as the "core" of the business which Congress intended to withdraw from federal regulation. *Id.* Under each of these alternative criteria, Blue Shield's prescription drug insurance policies and the Pharmacy Agreement qualify as the "business of insurance."

The prepaid prescription drug insurance sold by Blue Shield protects against the risk that the insured might require drugs as prescribed by his doctor. In consideration of the premium, Blue Shield agrees to contract with Participating Pharmacies to furnish drugs to its insureds and to reimburse the pharmacies on behalf of the insureds for each prescription filled. The risk assumed by Blue Shield is therefore in the form of a contractual obligation to make payments to Participating Pharmacies

in the amounts and on the terms specified in the policy and Pharmacy Agreement. The policies and the Pharmacy Agreement thus display the "earmark" of insurance—the "underwriting of risks" in exchange for a premium. *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 73 (1959).

Insuring the policyholder against health care risks by providing him with a source of health care goods and services, rather than by reimbursing him in cash, is a traditional feature of Blue Shield and other health insurance plans. It is a form of insurance of which Congress was aware when it passed the McCarran Act. A major objective of insurance plans utilizing health care provider agreements is to reduce premiums by containing the costs of claims payments and by reducing administrative expenses. By contracting in advance with the provider, the insurer is able to predict more accurately the amounts which will have to be paid in satisfaction of claims and to limit escalation in claims costs during the term of the policy. The provider agreements also facilitate computer processing of claims, thereby decreasing administrative costs. As a result, the insurer is able to offer lower premium rates and a higher level of coverage. Because of these advantages, Blue Shield has chosen to extend this form of health insurance to cover prescription drugs in a manner similar to coverage of physicians' and hospitals' services.

The Pharmacy Agreement is the means by which the benefits provisions of the policy are implemented. Because Blue Shield has agreed to furnish policy benefits to its insureds through providers of prescription drugs, the only way such benefits can be guaranteed is through contractual arrangements with pharmacies. The failure to provide Participating Pharmacies which permit the insured to obtain drugs on the terms and for the amounts stated in the policies would constitute a breach of the

contract of insurance. The reliability of Blue Shield's drug policies is, as a consequence, substantially dependent upon its entering into Pharmacy Agreements for the benefit of its insureds.

The Pharmacy Agreement is also the means by which policyholder claims are satisfied. Blue Shield's chosen method of claims settlement, *viz.*, contracting with pharmacies to provide drugs under a specified reimbursement formula, was designed to slow the rate of increase in claims payments and to provide the insured with fuller compensation for his or her losses. Blue Shield's choice of the manner in which policy benefits are to be provided and the amounts to be paid on behalf of the insured is central to the enforcement of the insurance contract and, therefore, central to the policyholder-insurer relationship.

Finally, the rates charged by Blue Shield for its drug policies are determined primarily by the costs of drugs provided to its policyholders. The contractual arrangements between Blue Shield and Participating Pharmacies governing the amount of reimbursement for drugs therefore have a substantial impact not only on the prices charged by Blue Shield to its policyholders but also on its status as a solvent and reliable insurer.

Because it has a direct impact upon the type, interpretation, enforcement and reliability of the policy, the Pharmacy Agreement is thus part of the "business of insurance." Every other lower court decision in point has so interpreted and applied the standards established in *National Securities*, a fact conceded by the Court of Appeals below. (App. 135a-136a)

Consistent with this uniform application of the *National Securities* criteria, Texas considers an insurer to be engaging in the "business of insurance" when "furnishing the prescription service required by its service

agreement and pharmacy contracts." (App. 482a) Indeed, the very policies and the Pharmacy Agreement here in issue were necessarily considered by the State to be the "business of insurance" when it subjected them to the regulatory requirements of the Texas Insurance Code and authorized their use in the State. This form of administrative regulation, conducted pursuant to statutes specifically enacted in response to the McCarran Act, is the type of regulation to which Congress intended federal deference.

Because the Pharmacy Agreement is thus part of the "business of insurance," the pharmacy petitioners were engaged in that "business" when they executed and implemented the Agreement. Failure to extend the McCarran Act's immunity to both parties to the provider agreement would, contrary to the intent of Congress and the *National Securities* decision, restrict the exemption to the "business of insurance *companies*" rather than to the "business of *insurance*."

Reversal of the decision below is necessary not only because the Court of Appeals misapplies *National Securities*, but also because it subverts the purpose of the McCarran Act. The central objective of the Act was to renounce federal jurisdiction where it might result in nullifying or restricting state regulation of the insurer-insured relationship. By preventing or deterring insurers from guaranteeing "the provision of services on a simple 'cost-plus' basis or any other basis which might be more economical than the retail purchase of [prescription drugs]" (App. 129a), the Court of Appeals undermines this basic policy of the Act and, indeed, strikes at the heart of state regulation of health insurance. State insurance commissioners, acting in the interest of the insurance consuming public, would effectively be deprived of the ability to maintain health insurance rates at reasonable levels through encouragement and approval of cost containment measures such as provider agreements.

Because Blue Shield's Pharmacy Agreements are functionally inseparable from a "type of policy" which has long been a part of the business of health insurance, and because the Agreements directly relate to the "interpretation, reliability and enforcement" of the policy, the judgment of the Court of Appeals below should be reversed.

ARGUMENT

I. THE "BUSINESS OF INSURANCE" INCLUDES A CONTRACT BETWEEN AN INSURER AND A HEALTH CARE PROVIDER TO FURNISH BENEFITS OWED TO POLICYHOLDERS UNDER THE INSURER'S HEALTH CARE POLICIES

A. Introduction

In 1869, this Court held that insurance transactions were not interstate commerce within the meaning of the commerce clause and, therefore, were not subject to regulation by Congress. *Paul* v. *Virginia*, 75 U.S. (8 Wall.) 168 (1869). Seventy-five years later, however, in *United States* v. *South-Eastern Underwriters Association*, 322 U.S. 533 (1944), the Court determined that the insurance business is part of interstate commerce and is fully subject to the federal antitrust laws.

Congress promptly responded to the *South-Eastern Underwriters* decision by passing the McCarran Act.[12] It is the basic policy of the Act that "the continued regulation and taxation by the several States of the business of insurance is in the public interest . . . ." 15 U.S.C. § 1011 (1976). (Add. 1a) The "business of insurance" and "every person engaged therein" are therefore to be governed by "the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. 1012(a) (1976). (Add. 1a)

[12] As noted in SEC v. National Securities, Inc., 393 U.S. 453, 458 (1969), "[t]he McCarran-Ferguson Act was the product of [Congress'] concern" about "the inroads the [*South-Eastern Underwriters*] decision might make on the tradition of state regulation of insurance."

Under the Act, the federal government is removed from the field of insurance regulation in two distinct ways. First, with respect to federal legislation generally, the Act declares that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." 15 U.S.C. § 1012(b) (1976). (Add. 1a) Second, the Act expressly exempts the "business of insurance" from the Sherman Act, the Clayton Act and the Federal Trade Commission Act "to the extent that such business is . . . regulated by State law," 15 U.S.C. § 1012(b) (1976) (Add. 1a), except that the Sherman Act remains applicable to "boycott, coercion, or intimidation." 15 U.S.C. § 1013(b) (1976). (Add. 2a)

Among the federal statutes regulating competition, the McCarran Act is unique. It represents the single instance where Congress, although having the power to regulate competition in or affecting interstate commerce, has explicitly renounced the exercise of such power in deference to state regulation.[13] The area reserved to the states is not dependent upon the importance of the state's interests vis-a-vis federal interests, or upon the potential inconsistency of the state's regulatory scheme with the federal antitrust laws, but rather only upon the state's decision to occupy the field.[14]

[13] As one of the few express exemptions from the Sherman Act, the McCarran Act was enacted by Congress to accommodate "the special characteristics of a particular industry." National Soc'y of Professional Engineers v. United States, No. 76-1787 (decided April 25, 1978), Slip Op. at 9, 10 n.24.

[14] The McCarran exemption is thus far broader than the implied antitrust exemption established in Parker v. Brown, 317 U.S. 341

In its first decision applying the Act, this Court held that "Congress' purpose was broadly to give support to existing and future state systems for regulating and taxing the business of insurance" and "to throw the whole weight of [the Congress'] power behind the state systems," notwithstanding the fact that "they differ greatly in [their] scope and character" from state to state.[15] *Prudential Insurance Co.* v. *Benjamin*, 328 U.S. 408, 429-430 (1946).

Antitrust immunity exists under the McCarran Act for all conduct which constitutes part of the "business

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(1941), and subsequent cases, the latest of which is City of Lafayette v. Louisiana Power and Light Co., No. 76-864 (decided March 29, 1978). Indeed, Congress was specifically aware of the *Parker* case in considering passage of the McCarran Act, and expressly declined to limit the exemption to the narrow scope of the *Parker* decision:

> The Department of Justice also urged that the recent case of *Parker* v. *Brown* (317 U.S. 341), precludes the necessity of enacting the bill in order to preserve State regulation. *Parker* v. *Brown* dealt with a State commission authorized by State statute to enforce a program in conformity with, if not supplementary to, a Federal statute. Obviously, all State regulation concerning insurance does not and would not fall in such a category. [S. Rep. No. 1112, 78th Cong., 2nd Sess., at 5 (1944)]

See also H.R. Rep. No. 873, 78th Cong., 1st Sess., at 7 (1943); Cantor v. Detroit Edison Co., 428 U.S. 579, 608 n.4 (1976) (concurring opinion of Mr. Justice Blackmun). The House rejected an amendment to an early version of the McCarran Act which would have limited the exemption to acts specifically "required or authorized by State laws which affect or restrain interstate commerce . . . ." 78 Cong. Rec. 6563-64 (1944).

[15] The Act was intended to mandate federal deference to new or subsequent forms of state regulation, as well as to those forms of regulation existing in 1945. An important purpose of the Act was "to assure a more adequate regulation of [the insurance] business in the States by suspending the application of the Sherman and Clayton Acts for approximately two sessions of the State legislatures, so that the States and the Congress may consider legislation during that period." H.R. Rep. No. 143, 79th Cong., 1st Sess., at 3 (1945) (accompanying S. 340, which, as amended, became the Act). *See also* n.17, *infra*.

of insurance" and is "regulated" by state law. While the legislative history of the Act is replete with references to the state regulation requirement, there is little discussion of the scope of the term "business of insurance." In the course of passage of the Act, Congress did, however, demonstrate its intent that the term be broadly construed by declining to limit the exemption to specifically identified insurance industry practices and agreements.[16]

In *Securities and Exchange Commission* v. *National Securities, Inc.*, 393 U.S. 453 (1969), this Court found that the term "business of insurance" must be construed in the light of the Act's purpose and history. The Court held that that term includes the fixing of rates, the selling and advertising of policies and the licensing of companies and their agents. 393 U.S. at 460. Further, the Court gave effect to the broad purpose of the Act by holding that the "business of insurance" extends to all insurance practices which involve "[t]he relationship between insurer and insured," including:

> the type of policy which could be issued, [or]
>
> its reliability, interpretation, and enforcement . . ., [or]
>
> other activities of insurance companies [which] relate . . . closely to their status as reliable insurers. . . . [*Id.*]

These factors were recognized to comprise the very "core of the 'business of insurance'" (*id.*), *and the presence of any one of them* would be sufficient to classify a practice as part of that "business."

Consistent with the legislative intent that the "business of insurance" not be defined by any mechanical test, *National Securities* left the definition of the term sufficiently flexible to serve the changing needs of the in-

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[16] *See* 79 Cong. Rec. 1444 (1945) (remarks of Senator O'Mahoney).

dustry.[17] Accordingly, the application of the *National Securities* criteria requires a pragmatic analysis of the particular conduct involved, focusing on its impact upon the insurer-policyholder relationship. Under each of the *National Securities* standards for measuring this impact —the type of policy, its interpretation and enforcement and the insurer's reliability—Blue Shield's policies and Pharmacy Agreements directly and materially affect that relationship.

B. "The Type of Policy": Prepaid Health Insurance Implemented Through Provider Agreements Is an Established Part of the "Business of Insurance"

In *Securities and Exchange Commission* v. *Variable Annuity Life Insurance Co.*, 359 U.S. 65, 73 (1959), the "earmark" of insurance was described as the "underwriting of risks" in exchange for a premium. Here the risk insured against is the possibility that, during the term of the policy, the insured may suffer a financial loss arising from the purchase of prescription drugs, or that he may be financially unable to purchase such drugs. In consideration of the premium, Blue Shield assumes this risk by agreeing with its insureds to contract with Participating Pharmacies to furnish the needed drugs and to reimburse the Pharmacies for each prescription filled for the insured. In short, each of the fundamental elements of insurance is present here—the payment of a premium in exchange for a promise to indemnify the insured against losses upon the happening of a specified contingency.

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[17] *See also* SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65, 71 (1959):

> We realize that . . . insurance is an evolving institution. Common knowledge tells us that the forms have greatly changed even in a generation. And we would not undertake to freeze the concepts of "insurance" . . . into the molds [it] fitted when [the McCarran Act was] passed.

The prescription drug insurance program at issue is an example of prepaid health insurance generally. While this form of prescription drug insurance is a relatively recent development, the use of health care providers to furnish benefits owed to policyholders is a traditional feature of Blue Shield and Blue Cross health insurance plans. This method of insuring against health care risks has been described by one court as follows:

> In its contracts with subscribers [Blue Cross] agrees to furnish them needed health care services in return for premiums paid by them, or on their behalf (e.g., by employers). In order to carry out these obligations Blue Cross contracts with eligible hospitals. In a typical situation, a subscriber goes to a member hospital, presents his or her Blue Cross card, and receives health care services and the hospital sends the bill directly to Blue Cross. On the other hand, a patient insured under a traditional, private health insurance policy is billed for the services he receives and is entitled to receive cash indemnification by his insurer in an amount determined by his particular policy.
>
> Some of Blue Cross' subscriber agreements include indemnification provisions together with service benefit provisions. The indemnity clause comes into play when a subscriber receives care from a non-member hospital. Under most plans, Blue Cross' obligation is a relatively small fraction of the total charge for the service. For example, a subscriber may collect fifty dollars for the first day of hospitalization and twenty-five dollars for each subsequent day while the hospital's charge exceeds two hundred dollars per day. Blue Cross' role as an indemnity insurer of health care bills is relatively modest, compared to its service benefits business. [*Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 417 F. Supp. 1104, 1106 (E.D.Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, —— U.S. ——, 98 S. Ct. 186 (1977)]

Prepaid prescription drug policies are merely an extension of this form of insurance to cover a different health care risk.

Texas Blue Shield was established in 1939 (App. 291a) and has been contracting directly with providers for the benefit of its insureds since that time. As the Attorney General of Texas has noted, "group health or group medical plans" with provider agreements of the type offered by Blue Shield "came into vogue during the depression." (App. 478a) Indeed, at the time of passage of the McCarran Act, Congress was aware of the use in the health insurance business of third-party provider agreements similar to those in issue here. Attorney General Biddle, in testimony during joint Congressional committee hearings on early versions of the McCarran Act, revealed that he had authorized the Government to bring the *South-Eastern Underwriters* case because of his belief that the Supreme Court, in *American Medical Association* v. *United States*, 317 U.S. 519 (1943), had held that prepaid health care plans were the business of insurance and were subject to the antitrust laws. The *AMA* case bears strong similarities to the instant case. It involved allegations that non-participating providers—physicians—had attempted to boycott a group health service ("Group Health") providing "medical care and hospitalization on a risk-sharing prepayment basis." 317 U.S. at 526. Group Health insured its members against health care risks by employing "physicians on a full time salary basis" and by seeking "hospital facilities for the treatment of members . . . ." *Id.* In current terminology, Group Health had entered into agreements with "participating providers." The Attorney General characterized this arrangement as the "business of insurance":

> [The *American Medical Association*] case involved a conspiracy against Group Health, in its essence indistinguishable from insurance although not formally so termed.
>
> * * * *
>
> [The Supreme Court's] definition [of Group Health's business] fits but one word, and that perfectly. The word is "insurance." [*Joint Hearing Before the Subcommittees of the Committees on the Judiciary on S. 1362, H.R. 3269 and H.R. 3270*, 78th Cong., 1st Sess., at 41 (1944)]

Blue Shield's prescription drug insurance program represents one response to the rapid escalation in the costs of health care services and to the urgings of government officials, employers and labor unions to provide health care delivery systems within the financial reach of the general public. A chief advantage of the Blue Shield plan is its cost savings to the policyholder. Unlike life insurance and some forms of property and casualty insurance, where the maximum dollar amount of the insuance companies' liability to the beneficiary is stated in the policy, prescription drug insurance involves an indeterminate liability. Because illnesses vary in frequency, duration and severity, and because the prices of prescription drugs are subject to rapid inflation, no one knows in advance of the insured's illness what monetary obligation Blue Shield will be required to bear to satisfy his or her claim. By contracting in advance with pharmacies to provide drugs under a specific reimbursement formula, Blue Shield is able to contain costs and predict more accurately the amounts it will be required to pay in satisfaction of its contractual obligations to its insureds. It is also protected, during the term of the policy and Pharmacy Agreement, against inflation in the retail mark-up on the acquisition costs of prescription drugs. Finally, it is able to reduce the administrative costs of processing claims by having the Participating Pharmacy file claims data on a composite rather than individual claims basis, using forms permitting direct

input into Blue Shield's computers. Because of these factors, Blue Shield is able to offer comparatively lower premium rates than those for health insurance policies where its liability is open-ended.

It is also able to provide a higher level of coverage for its policyholders. By virtue of the cost containment and claims predictability effects of the Pharmacy Agreement, Blue Shield is able to insure the policyholder for all but $2.00 of the drug purchase price. Conversely, because pharmacy prices are significantly less predictable and subject to unlimited escalation in the absence of the Pharmacy Agreement, Blue Shield can insure against only 75 percent of the risk borne by the insured in purchasing drugs from a non-participating pharmacy. Indeed, because a non-participating pharmacy may charge *more* than the "usual and customary" price upon which cash reimbursement to the insured is based, the insured may recover even less of his or her outlay.

In the exercise of its business judgment as an insurer, Blue Shield has thus decided to issue policies providing for goods and services benefits rather than offering cash indemnification exclusively. While Blue Shield could have decided otherwise, it is the very choice of "the type of policy which could be issued" which is itself the "business of insurance." Blue Shield's objective in electing to use a participating provider plan—the containment of claims costs—is also central to the "business of insurance."

The usefulness of prepaid provider plans in reducing health care costs and policyholder premiums has been consistently recognized by federal and state governments. The Council on Wage and Price Stability, for example, has determined that prepaid drug plans of the type in issue here "can reduce retail drug prices an estimated

15% or more." [18] The concern of state insurance commissioners over accelerating health care costs, and the exercise of their regulatory powers over prepaid health plans to contain such costs, have been documented in other litigation.[19] Virtually all states regulate such plans under their insurance codes, including special legislation designed to further the states' cost containment objective.[20]

The widespread use of group prepaid provider plans by commercial health insurers and health maintenance organizations,[21] as well as by Blue Shield and Blue Cross, is evidence of their importance to the business of health insurance. In addition to covering prescription drugs and physician and hospital services (App. 46a), many provider plans now cover dental, optometric and audiological goods and services. Prepaid health insurance has increasingly been among the fringe benefits negotiated in labor-management collective bargaining agreements.[22]

The decision below stands alone in its unrealistic attempt to separate the health care provider agreement

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[18] *Council on Wage and Price Stability*, EMPLOYEE HEALTH CARE BENEFITS: LABOR-MANAGEMENT INNOVATIONS IN CONTROLLING COSTS, 41 Fed. Reg. 40305 (1976).

[19] *See, e.g.*, Travelers Ins. Co. v. Blue Cross of Western Pennsylvania, 481 F.2d 80, 83-84 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); Frankford Hospital v. Blue Cross of Greater Philadelphia, 417 F.Supp. 1104, 1106-07 (E.D. Pa. 1976), *aff'd*, 554 F.2d 1253 (3d Cir.), *cert. denied*, —— U.S. ——, 98 S. Ct. 186 (1977); Doctors, Inc. v. Blue Cross of Greater Philadelphia, 431 F.Supp. 5, 6-7, 10 (E.D. Pa. 1975), *aff'd*, 557 F.2d 1001 (3d Cir. 1977).

[20] A full discussion of state regulation is contained in the brief of the National Association of Insurance Commissioners ("NAIC") as *amicus curiae*.

[21] *See* discussion in *amicus curiae* brief of NAIC.

[22] In addition to the U.A.W. drug program, the Council on Wage and Price Stability notes that both the United Federation of Teachers (New York City) and the International Ladies' Garment Workers Union have adopted similar plans. *Op. cit.*, n.18.

from the underlying contract of insurance. In applying the *National Securities* criteria, all other courts have uniformly held that participating agreements between physicians and a health care insurer, *Anderson* v. *Medical Service of District of Columbia*, 551 F.2d 304 (4th Cir. 1977), *aff'g* 1976-1 CCH Trade Cas. ¶ 60,884 (E.D. Va. 1976); participating agreements between hospitals and insurers, *Travelers* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973); *Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 554 F.2d 1253 (3d Cir.), *cert. denied*, —— U.S. ——, 98 S. Ct. 186 (1977); *Doctors, Inc.* v. *Blue Cross of Greater Philadelphia*, 557 F.2d 1001 (3d Cir. 1977), *aff'g* 431 F. Supp. 5 (E.D. Pa. 1975);[23] and participating agreements between dentists and insurers, *Manasen* v. *California Dental Services*, 424 F. Supp. 657 (N.D. Cal. 1976), *appeal pending*, Nos. 77-1751 and 77-

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[23] The court below sought to distinguish the *Travelers* and *Doctors, Inc.* cases on the ground that the state insurance commissioner had regulated hospital reimbursement rates and had urged insurers to contain such rates in order to maintain premiums at reasonable levels. (App. 130a) The court, however, has confused the "state regulation" and "business of insurance" requirements of the McCarran Act. Whether or not provider agreements are regulated by the state, they are part of the "business of insurance" if they meet the *National Securities* criteria, as they were found to do in *Travelers* and *Doctors, Inc.* Moreover, as discussed *infra*, at 31-35, the court's factual premise is mistaken; Texas has exercised its regulatory powers over Blue Shield's Pharmacy Agreements.

The court below also relied heavily on Battle v. Liberty Nat. Life Ins. Co., 493 F.2d 39 (5th Cir. 1974), *cert. denied*, 419 U.S. 1110 (1975), for the proposition that provider agreements are not necessary appendages of the insurance contract. (App. 131a-132a) As the District of Columbia Court of Appeals has recognized, however, *Battle* is inapposite where there is a *direct* contract between the insurer and the provider of services, and where the services provided are *required* by the policy of insurance. *See* Proctor v. State Farm Mut. Auto. Ins. Co., *supra*, 561 F.2d at 270; *see also* Frankford Hospital v. Blue Cross of Greater Philadelphia, 417 F.Supp. 1104, 1110-11 (E.D. Pa. 1976).

1752 (9th Cir.), are an integral part of the "business of insurance."[24] The common feature of these cases has been the use of provider agreements by the insurer to furnish a source of health care services or goods to the insured in lieu of cash indemnification. The provider agreements in all of these cases incorporated reimbursement formulas establishing ceilings or other restrictions on the costs which would be recompensed, thus containing the costs of claims and reducing premiums. In addition, in each case the insurance policy provided a lower percentage level of benefits or lesser coverage to the insured if he or she patronized non-participating providers, because the cost containment provisions of the provider agreement were not applicable. Every court faced with this form of prepaid health insurance—save for the court below—has found that the direct and substantial impact on rates, the very nature of the type of policy issued, and the insurer's obligation to provide services to its insureds together bring policies and provider agreements such as these well within the "business of insurance."

C. The Policy's "Reliability and Enforcement": Blue Shield's Pharmacy Agreements Are Indispensable to the Furnishing of Policy Benefits and Settling of Claims

The reliability of Blue Shield's policies is principally dependent upon Blue Shield's contracting with Participating Pharmacies for the benefit of its insureds. The benefits section of Blue Shield's drug policy provides that the insureds (1) "shall be entitled to receive covered drugs from any participating provider as a benefit here-

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[24] *See also* Nankin Hospital v. Michigan Hospital Serv. 361 F. Supp. 1199 (E.D. Mich. 1973) (participating agreements between hospitals and insurer); St. Bernard General Hospital v. Hospital Service Ass'n of New Orleans, Inc., 1978-1 CCH Trade Cas. ¶ 61,868 (E.D. La. 1977) (same); Winters v. Kansas Hospital Service Ass'n, Inc., 1975-1 CCH Trade Cas. ¶ 60,140 (D. Kan. 1974) (same).

under" and (2) "shall be required to pay no more than the drug deductible for each of such covered drugs." (App. 55a) In satisfaction of this dual obligation to insureds, the Pharmacy Agreement first serves to provide a guaranteed source of goods and services.

Second, after the insured's loss has arisen, the Pharmacy Agreement serves as the mechanism through which the claims of Blue Shield's insureds are settled. The Pharmacy Agreement thus implements "the insurance company's agreement, in return for a premium, to make payments to or on behalf of the policyholder for losses arising out of" the risks covered by the insurance contract. *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, 561 F.2d 262, 267 (D.C. Cir. 1977), *pet. for cert. pending*, No. 77-580. The process of determining the manner in which claims payments will be made and the amount to be paid on behalf of or to insureds is certainly peculiar to the "business of insurance." [25] It is nothing less than the "discharge of [the] contractual obligation . . . at the heart of the relationship between insurer and insured, and is directly connected with the reliability, interpretation, and enforcement of the insurance contract." *Id.* By dealing directly with the provider of goods and services to the insured, the insurer hopes to "slow the rate of increase in the claims payments required to satisfy [its] contractual obligation to [its] policyholders." *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, *supra*, 561 F.2d at 268. This goal is intimately connected to the insurer-insured relationship.

[25] In at least one instance during the legislative debates over passage of the McCarran Act, the "servicing of claims" was recognized to constitute the "business of insurance." 78 Cong. Rec. 6550 (1944) (remarks of Congressman Ploeser).

D. "Status as a Reliable Insurer": The Pharmacy Agreement Has a Direct Impact on Premium Levels and Thus on Blue Shield's Solvency and Reliability

A consistent line of decisions construing the McCarran Act has held that insurance company practices having a direct and substantial bearing upon rates are included within the "business of insurance" because (1) the price a policyholder pays for his coverage is a central aspect of the insurer-insured relationship, and (2) rate levels largely determine the solvency and reliability of the insurer. For example, in *Travelers Insurance Co.* v. *Blue Cross of Western Pennsylvania*, 481 F.2d 80, 83 (3d Cir.), *cert. denied*, 414 U.S. 1093 (1973), the Court of Appeals found Blue Cross' provider agreements with hospitals to be within the "business of insurance" because of the "interrelationship of hospital payments and subscribers' rates." [26] *See also Frankford Hospital* v. *Blue Cross of Greater Philadelphia*, 554 F.2d 1253 (3d Cir.), *cert. denied*, —— U.S. ——, 98 S. Ct. 186 (1977); *Doctors, Inc.* v. *Blue Cross of Greater Philadelphia*, 557 F.2d 1001 (3d Cir. 1977), *aff'g* 431 F. Supp. 5 (E.D. Pa. 1975); *Proctor* v. *State Farm Mutual Automobile Insurance Co.*, *supra*, 561 F.2d at 268-69.

[26] The testimony of Pennsylvania Insurance Commissioner Herbert S. Denenberg in the *Travelers* case underscores the direct relationship between provider reimbursement rates and premium levels:

> Q. Commissioner, in carrying out the responsibilities of your office as you see them, what relation, if any, have you found to exist between a Blue Cross plan reimbursement contract with its hospitals and the Blue Cross plan subscriber rates?
>
> A. Well, these two things are really indivisible aspects reflecting the same economic forces. If you do not have a sound contract between Blue Cross and the hospitals that controls cost and quality then the Blue Cross rate to the subscribers is going to be unreasonable. [481 F.2d at 83, n.9.]

Since the cost of prescription drugs is the only risk covered by Blue Shield's drug policy, the premiums it charges are based largely upon the cost of drugs provided to its policyholders.[27] The primary objective of the contractual arrangements between Blue Shield and Participating Pharmacies is to contain these costs and make them more predictable for rate-making purposes, so as to enable an economical and efficient program of prescription drug insurance. The Pharmacy Agreement thus plays an essential role in Blue Shield's rate-making process. That process is at the core of the "business of insurance": "Certainly, the fixing of rates is part of this business; that is what *South-Eastern Underwriters* was all about." *Securities & Exchange Commission* v. *National Securities, Inc.*, *supra*, 393 U.S. at 460.

The Court of Appeals did not deny the existence of this close interrelationship of claims costs and rates, but nonetheless concluded that an impact upon rates was not, standing alone, enough to bring an activity within the "business of insurance." (App. 137a) It is no doubt true that not all cost reduction by insurers constitutes exempt conduct regardless of the substantiality of the effect on rates. The sufficiency of the impact on rates, however, is unquestionable where, as here, the insurer has acted to contain the cost of *claims* for the *sole* risk it has underwritten—the purchase price of prescription drugs. The interdependence of drug prices and policy rates is, moreover, not the only means by which the Pharmacy Agreement has a direct impact on the insurer-insured relationship. As already noted, the Agreement is functionally inseparable from the type of benefits provided in the

[27] The administrative and overhead costs of selling policies and processing claims is the other major determinant of rates. This element also is affected by Blue Shield's Pharmacy Agreements, which enable automated processing of claims and thus lower administrative costs. (Helis Depo., App. 283a-284a)

policy, the coverages specified and the manner of handling claims. In sum, the Pharmacy Agreement is at the core of the basic prepaid insurance undertaking.

E. Regulation of Blue Shield's Policies and Pharmacy Agreements Under the Texas Insurance Code Confirms That They Are the "Business of Insurance"

The pervasive regulation of Blue Shield's prescription drug policies and the Pharmacy Agreement by the Texas State Board of Insurance further demonstrates that Blue Shield's arrangements with pharmacies are part of the "business of insurance." [28]

The Attorney General of Texas has long considered that prescription drug insurance plans (including provider agreements) constitute the "business of insurance" in Texas. With regard to a prepaid prescription drug program identical in concept and operation to the Blue Shield plan, the Attorney General concluded that the insurer "would be engaging in the business of insurance, in furnishing the prescription service required by its service agreements and pharmacy contracts." (App. 482a; for description of plan, *see* App. 475a-477a.)

[28] It is, of course, true that the meaning of the "business of insurance" is a federal question. SEC v. Variable Annuity Life Ins. Co., 359 U.S. 65, 69 (1959). Nevertheless, in the McCarran Act "Congress was legislating concerning a concept which had taken on its coloration and meaning largely from state law, from state practice, from state usage." *Id.* It is noteworthy that the original draft of the McCarran Act was proposed by the National Association of Insurance Commissioners. *See* 79 Cong. Rec. 1488 (1945) (remarks of Senator Barkley). That draft incorporated the term "business of insurance" ultimately included in the final Act. Accordingly, the views of state regulators on what constitutes the "business of insurance", as evidenced by state regulatory enactments, are highly probative in construing the Act. Unlike the "annuity" contracts involved in *Variable Annuity*, however, there is here no lack of uniformity among the states on the nature of health care provider contracts. Virtually all states regulate such arrangements under their insurance codes, typically under special provisions governing non-profit insurers such as Blue Cross and Blue Shield. *See* discussion in *amicus curiae* brief of NAIC.

Texas' views on the nature of prepaid drug plans are even more strongly demonstrated by the State's actual regulation of the policies and Pharmacy Agreement in question. The former Deputy Commissioner of the State Board testified in this case that Blue Shield's drug policy and Pharmacy Agreement constitute the business of insurance, and are subject to the full regulation, control and supervision of the State Board. (Connor Depo., App. 394a-395a)

Regulation of health insurance policies in Texas assumes several forms. Article 3.42 of the Insurance Code, *Tex. Ins. Code Ann.* art. 3.42 (Supp. 1977), passed shortly after the McCarran Act, requires state approval prior to issuance of individual and group health insurance policies. (Add. 2a-4a; Pogue Depo., App. 326a-327a) Broad discretion is vested in the State Board to approve or disapprove proposed policies. (Pogue Depo., App. 326a; Connor Depo., App. 393a) Policies may be rejected for any failure to comply with the Insurance Code, or for any "provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, deceptive or contrary to law or the public policy of the State." (Add. 4a; McAnelly Depo., App. 412a) Use of unapproved policies subjects the issuer to civil fines. (Pogue Depo., App. 331a)

In addition, Article 21.21 of the Texas Insurance Code, *Tex. Ins. Code Ann.* art. 21.21 (1963), was enacted in 1951 for the express purpose of regulating unfair competition and unfair practices in the business of insurance. (Add. 4a-14a) Article 21.21 was specifically intended by its draftsmen to respond to the invitation of the McCarran Act to withdraw from federal control the very conduct attacked by respondents in this action and to place such

conduct under state control.[29] All policies are examined by the State Board in light of the regulatory requirements of Article 21.21, as well as those of Article 3.42. (Pogue Depo., App. 335-336a; Connor Depo., App. 398a) The Board has extensive investigative powers under Article 21.21, and it may prohibit unlawful practices by cease and desist orders, violation of which will result in civil penalties. *Tex. Ins. Code Ann.* art. 21.21 §§ 5-7, 10 (1963). (Add. 7a-9a) Later amendments to the Act, *Tex. Ins. Code Ann.* art. 21.21 §§ 14-15 (Supp. 1977), authorize the Board (through the Attorney General) temporarily or permanently to enjoin unfair practices and to recover damages on behalf of insureds. (Add. 10a-12a) Policyholder individual and class actions are also permitted. *Tex. Ins. Code Ann.* art. 21.21 §§ 16-17 (Supp. 1977) (Add. 12a-14a) A related provision, Article 21.21-2, *Tex. Ins. Code Ann.* art. 21.21-2 (Supp. 1977), prohibits unfair practices in claims settlement. (Pogue Depo., App. 336a; Connor Depo., App. 399a)

Blue Shield's prescription drug policies and Pharmacy Agreements were reviewed by the State for compliance with these statutes. Indeed, in 1969, the State Board initially disapproved Blue Shield's prescription drug policy and the annexed Pharmacy Agreement because it believed the agreement might violate Article 21.21. The reason for initial disapproval—alleged discrimination between insureds who patronized participating pharmacies

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[29] Statutes like Article 21.21, which specifically prohibit unfair competition and unfair practices in the insurance business, constitute state regulation and thus trigger the McCarran Act exemption. *See, e.g.*, Dexter v. Equitable Life Assurance Soc'y, 527 F.2d 233, 236 (2d Cir. 1975); Crawford v. American Title Ins. Co., 518 F.2d 217, 219 (5th Cir. 1975). It was exactly this form of "prohibitory legislation" authorizing "enforcement through a scheme of administrative supervision" which was found to be sufficient state regulation within the meaning of the McCarran Act in FTC v. National Casualty Co., 357 U.S. 560, 564 (1958). The Court noted that, at the time the *National Casualty* complaints were filed, thirty-six states had enacted the "Model Unfair Trade Practices Bill for Insurance" drafted by the state commissioners. *Id.*, at 564, n.6. It was this bill that was passed as Article 21.21 of the Texas Code.

and those who patronized non-participants—was similar to respondents' present objections. (App. 365a-366a) Thereafter, the proposed insurance program remained under consideration by the State Board and the Commissioner subsequently authorized the program. (App. 370a-371a) The record demonstrates that the State Board could have, "almost as an injunction matter," prohibited the issuance of the policy and the concomitant use of the Pharmacy Agreement. (Connor Depo., App. 395a) The Board, however, determined not to do so:

> [I]t was almost as if we had a Motion in Limine to stop the doing of what they were proposing to do. We could have stopped it through the medium of refusing to approve and refusing to exempt the contract on which activity was being pursued, but as these Exhibits indicate, the departmental action was to refer the matter to the Attorney General and not to block the doing of what was being done through the device of refusing to allow a form to be used. [Connor Depo., App. 395a]

In 1974, when Blue Shield submitted an identical policy to the State Board (App. 374a-376a), it was promptly approved for issuance by order of the Commissioner.[30]

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[30] In addition to regulation under the Texas Insurance Code, anticompetitive practices in the "business of insurance" are prohibited by the Texas antitrust laws and are subject to civil and criminal penalties. *Tex. Bus. & Comm. Code Ann.* §§ 15.02, 15.04, 15.29, 15.32, 15.33 (1963). (Add. 14a-17a) Respondents' allegation that Blue Shield and the pharmacy petitioners conspired to fix the retail price of drugs through the use of the Pharmacy Agreement (App. 7a-8a) falls within the scope of these state statutes. Respondents so concede by including in their complaint a pendent claim under the Texas antitrust laws based upon the same facts that are alleged to give rise to a violation of the federal antitrust laws. (App. 10a) The policies and Pharmacy Agreements here in issue were referred by the State Board, after its review, to the Texas Attorney General for consideration under the state antitrust statutes. (App. 370a-371a) No action was ever commenced against petitioners. (McDonald Aff., App. 49a; Connor Depo., App. 396a) The existence of state antitrust laws proscribing the conduct complained of constitutes

In sum, Texas considers Blue Shield's policies and provider agreements to be the "business of insurance" and, as such, subject to the full panoply of state insurance regulation: the "prior approval" system which was the prevalent form of state regulation when Congress passed the McCarran Act;[31] the unfair practices legislation passed in response to the McCarran Act; and state antitrust legislation specifically directed at the "business of insurance."

II. BECAUSE THE PHARMACY AGREEMENTS CONSTITUTE THE "BUSINESS OF INSURANCE," THE PHARMACY PETITIONERS ARE ALSO PROTECTED BY THE McCARRAN ACT

In a terse footnote (App. 135a), the Court of Appeals apparently held that non-insurance companies, including the pharmacy petitioners, are automatically ineligible for the McCarran Act exemption. However, "[t]here is nothing in the McCarran Act which limits the 'business of insurance' to the business of insurance companies." *Lowe* v. *Aarco-American, Inc.*, 536 F.2d 1160, 1162 (7th Cir. 1976).[32] To the contrary, the protection afforded by the

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regulation within the meaning of the McCarran Act sufficient to displace the federal antitrust laws. *See, e.g.*, Meicler v. Aetna Cas. and Sur. Co., 506 F.2d 732, 734 (5th Cir. 1975).

Texas also regulates Blue Shield by means of its authority under Chapter 3 of the Code to grant or cancel licenses, require reports, compel maintenance of reserves and inspect financial condition and management practices. *See, e.g., Tex. Ins. Code Ann.* arts. 3.04, 3.06, 3.07, 3.28, 3.32, 3.35-3.36, 3.57 (1963 and Supp. 1977). (*See also* Bunnell Depo., App. 424-425a, 428a.) Violation of any provision of the Code subjects the insurer to possible loss of license or civil penalty. *Tex. Ins. Code Ann.* arts. 3.55, 3.70-9 (Supp. 1977).

[31] *See, e.g.*, 78 Cong. Rec. 6544 (1944) (remarks of Congressman Clason).

[32] A number of cases have determined that persons acting on behalf of insurers or insureds in the sale or enforcement of the

Act is expressly extended to the "*business* of insurance, *and every person engaged therein.*" 15 U.S.C. § 1012(a) (1976) (emphasis added). It is the nature of the conduct —in this case, the Pharmacy Agreement—which must be examined, not the identity of the parties.

In this respect, the McCarran exemption is analogous to the labor exemption from the antitrust laws. Since it is the collective bargaining *agreement* which is immune, the exemption is available to employers as well as unions. *See, e.g., Mackey* v. *National Football League*, 543 F.2d 606, 612 (8th Cir. 1976), *cert. dism'd* (September 12, 1977, No. 76-932); *Scooper Dooper, Inc.* v. *Kraftco Corp.*, 494 F.2d 840, 847 n.14 (3d Cir. 1974). Labor immunity thus applies to both unions and employers if the provisions of the collective bargaining agreement sufficiently relate to the conduct sought to be protected, *i.e.*, if they relate to proper subjects of collective bargaining. *See, e.g., Amalgamated Meat Cutters* v. *Jewel Tea Co.*, 381 U.S. 676 (1965).[33]

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contract of insurance are engaged in the "business of insurance." Insurance agents and brokers, SEC v. National Securities, Inc., *supra*, 393 U.S. at 460; U.S. v. New Orleans Ins., Exch., 148 F. Supp. 915 (E.D. La.), *aff'd per curiam*, 355 U.S. 22 (1957); Lowe v. Aarco-American Inc., *supra*, 536 F.2d at 1162; and premium finance companies, Lowe v. Aarco-American, Inc., *supra*, 536 F.2d at 1162; Cochran v. Paco, 409 F.Supp. 219, 222 (N.D. Ga. 1975), have been found to engage in that business. The role of Participating Pharmacies in settling claims and providing policy benefits is intrinsically no different. As the District Court found, the pharmacy petitioners are "an integral part of the overall scheme of insurance coverage which is regulated by state law." (App. 113a)

[33] The availability of other statutory antitrust exemptions is also to be assessed in terms of the conduct involved rather than the status of the parties. For example, in Hughes Tool Co. v. Trans World Airlines, Inc., 409 U.S. 363 (1973), this Court found that transactions between an air carrier, fully regulated by the Civil Aeronautics Board (CAB), and its owner, which was not CAB-licensed, were nonetheless exempt from the Sherman Act under § 414 of the Federal Aviation Act of 1958, 49 U.S.C. § 1384 (1970), because the *transactions* in question had been regulated by the

The McCarran Act is similarly conduct-oriented, for it applies to all activities having the requisite linkage to the insurer-insured relationship as defined in *National Securities*. Because it satisfies all of the criteria of *National Securities*, the Pharmacy *Agreement* constitutes the "business of insurance." *A fortiori*, the signatories to the contract are engaged in that business to the extent they execute and implement the contract.[34] Failure to extend the McCarran Act's immunity to the pharmacy petitioners therefore would be logically inconsistent with holding that the Agreement itself is exempt.

III. UNLESS REVERSED, THE DECISION OF THE COURT OF APPEALS WILL HAVE EXACTLY THE DISRUPTIVE EFFECT ON STATE INSURANCE REGULATION WHICH IT WAS THE PURPOSE OF THE McCARRAN ACT TO AVOID

The primary concern of the authors of the McCarran Act was avoiding the disruption of traditional state regulation that was thought likely to be caused by the *South-*

CAB. *See also* Scroggins v. Air Cargo, Inc., 534 F.2d 1124 (5th Cir. 1976), where the court found that a contract between CAB-regulated air carriers and a non-regulated trucker was immune under the Aviation Act because the contract had been approved by the Board.

[34] With the sole exception of the Court of Appeals below, every other court having occasion to review provider agreements has found that the *agreement* is part of the "business of insurance." *See* pp. 26-27, *supra*. Indeed, in one of those cases, Doctor's, Inc. v. Blue Cross of Greater Philadelphia, 557 F.2d 1001 (3d Cir. 1977), the Court of Appeals for the Third Circuit affirmed the lower court's dismissal (1977-2 CCH Trade Cas. ¶ 61,693 (E.D. Pa. 1975)) of the complaint as to a private health care and hospital advisory agency (as well as Blue Cross), even though the agency was not directly a party to Blue Cross' reimbursement contracts with hospitals. The agency had recommended to Blue Shield what hospital services should or should not be included in the provider agreement. The agency was dismissed as a defendant because "it is axiomatic that if Blue Cross has not violated the antitrust laws, [the agency] could not be guilty of conspiring with Blue Cross to violate those laws." 1977-2 CCH Trade Cas. at p. 72,481.

Eastern Underwriters decision.[35] Congress not only feared that state laws might be nullified, but also that a spate of litigation would ensue to determine which state statutes and regulations were preempted by the federal antitrust laws (and other statutes based on the commerce clause) and which were not.[36]

Each of these important legislative purposes would be vitiated or thwarted by the decision below. The potential for conflict between the Sherman Act and state insurance regulation is well demonstrated by the Court of Appeals' conclusion that "Blue Shield is not required to

[35] *See, e.g.*, 78 Cong. Rec. 6529-30 (1944) (remarks of Congressman Satterfield):

> The opinions of the minority in the South-eastern case should be listened to by the Congress with great respect. The admonition of Justice Stone must not go unheeded. The gravity of the situation is best described in the words of the Chief Justice when he said:
>
> > It's (the Supreme Court's) action in now overturning the precedents of 75 years governing a business of such volume and such wide ramification cannot fail to be the occasion for loosing a flood of litigation and of legislation, State and National, in order to establish a new boundary between State and National power, raising questions that cannot be answered for years to come, during which a great business and the regulatory officers of every state must be harassed by all the doubts and difficulties inseparable from a realignment of the distribution of power in our Federal system. These considerations might well stay reversal of established doctrine which promises so little advantage and so much harm. For me these considerations are controlling.

[36] *See, e.g.*, 78 Cong. Rec. 6549 (1944) (remarks of Congressman Michener). A related Congressional purpose was to prevent insurers from being placed in the dilemma of attempting to comply with conflicting state and federal regulatory strictures. *See, e.g.*, H.R. Rep. No. 143, 79th Cong., 1st Sess., at 2 (1945); H.R. Rep. No. 873, 78th Cong., 1st Sess., at 7 (1943); 78 Cong. Rec. 6454 (1944) (remarks of Congressman Vorys); 78 Cong. Rec. 6526 (1944) (remarks of Congressman Hancock); 78 Cong. Rec. 6527 (1944) (remarks of Congressman Miller); 78 Cong. Rec. 6556 (1944) (remarks of Congressman Graham).

guarantee the provision of services on a simple 'cost-plus' basis or any other basis which might be more economical than the retail purchase of [prescription drugs]." (App. 129a) Indeed, the court below would limit an insurer's means of "protect[ing] itself from rising costs" to "establish[ing] a periodically adjusted rate structure to reflect the impact of inflation." (App. 129a) Under this view, insurers could no longer employ any method, including the widely-used provider concept, of keeping health insurance premiums down by containing health care costs except at the risk of antitrust liability.

As this case so clearly demonstrates, removing health care provider agreements from the "business of insurance" will also effectively prevent the states from fostering the use of cost containment measures through the policy approval mechanism or otherwise. Notwithstanding that Texas has approved the use of prepaid drug policies utilizing Participating Pharmacies, the relief sought by respondents would preclude issuance of any policies except those granting reimbursement on the basis of the "usual and customary" drug price. Likewise, state regulation and maintenance of insurance company solvency would be hampered if insurers were prevented or deterred from containing claims costs through provider agreements.

In effect, the Court of Appeals has assumed a role properly reserved for the state insurance commissioner. It is the policy of the McCarran Act to allow the states freedom to determine—through their legislative and administrative processes—the best means of ensuring the availability of insurance at reasonable rates by insurers whose reliability is adequately safeguarded.[37] Congress

[37] A correlative purpose of the Act was to preserve state regulation because of the absence of any federal regulation specifically directed at the insurance industry. Quoting the dissents in *South-Eastern Underwriters*, the sponsors of the Act repeatedly noted

was aware that the federal antitrust laws' objective of unrestricted competition might conflict with these state regulatory goals,[38] and it granted priority to the latter.

The health insurance industry has long used provider agreements, the states have long exercised their regulatory authority over such agreements and the public has benefitted from the resulting lower rates. In these circumstances, this Court should reaffirm "the policy announced by Congress in the McCarran-Ferguson Act," a policy "on which the industry [has] had reason to rely." *State Board of Insurance* v. *Todd Shipyards Corp.*, 370 U.S. 451, 457 (1962). As this Court has noted in a similar context, failure to do so will permit the erosion of state insurance regulation through piecemeal litigation in the federal courts:

> The hearings on the McCarran Act reveal the complexities and difficulties of an attempt to unify insurance law on a nationwide basis, even by Congress. Courts would find such a task far more difficult.

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that the federal government, in contrast to the states, had "adopted no legislative policy and evolved no scheme of regulation with respect to the business of insurance." 78 Cong. Rec. 6541 (1944) (remarks of Congressman Fellows, quoting Chief Justice Stone's dissent). *See also* dissent of Mr. Justice Jackson, quoted *id.*

[38] Congress, for example, realized that rating bureaus, pooling arrangements, reinsurance treaties and other industry practices might not pass federal antitrust scrutiny but might nonetheless be considered by the states as necessary to preserve the reliability of insurers while also assuring reasonable rates. *See, e.g.*, H.R. Rep. No. 873, 78th Cong., 1st Sess., at 9 (1943); 78 Cong. Rec. 6527 (1944) (remarks of Congressman Miller). An express purpose of the Act was thus to grant the states the opportunity "to permit *agreements and contracts* by insurance companies which might otherwise be in violation of the Sherman and Clayton Acts." H.R. Rep. 143, at 3 (1945) (emphasis added); *see also* 79 Cong. Rec. 1443-4, 1486 (1945) (remarks of Senator McCarran). The Court of Appeals below ignored this aspect of the Act when it seemingly held that all anticompetitive conduct is not "peculiar" to the business of insurance and is thus ineligible for the exemption. (App. 137a-138a)

> Congress in passing laws is not limited to the narrow factual situation of a particular controversy as courts are in deciding lawsuits. And Congress could replace the presently functioning state regulations of . . . insurance by one comprehensive Act. Courts, however, could only do it piecemeal, on a case-by-case basis. Such a creeping approach would result in leaving . . . insurance largely unregulated for years to come. [*Wilburn Boat Co.* v. *Fireman's Fund Insurance Co.*, 348 U.S. 310, 319 (1955).]

In the words of Senator McCarran, the Act was "an invitation to the States to legislate in good faith." 79 Cong. Rec. 1487 (1945). Texas has done so through regulation specifically aimed at the relationship between insurer and insured. The Congressionally mandated policy of deference to this regulation can be effectuated only by construing the "business of insurance" to include a traditional and widely-used means of satisfying the insurer's obligations to its policyholders.

CONCLUSION

For the foregoing reasons, the judgment of the Court of Appeals for the Fifth Circuit should be reversed.

Respectfully submitted,

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ADDENDUM

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RELEVANT PROVISIONS OF McCARRAN-FERGUSON ACT

McCarran Act § 1, 15 U.S.C. § 1011 (1976):

Declaration of Policy.

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation of taxation of such business by the several States.

McCarran Act § 2, 15 U.S.C. § 1012 (1976):

Regulation by State Law; Federal law relating specifically to insurance; applicability of certain Federal laws after June 30, 1948.

(a) The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided*, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.

McCarran Act § 3, 15 U.S.C. § 1013 (1976):

Suspension until June 30, 1948, of application of certain Federal laws; Sherman Anti-Trust Act applicable to agreements to, or acts, of boycott, coercion, or intimidation.

(a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, and the Act of June 19, 1936, known as the Robinson-Patman Anti-discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

RELEVANT PROVISIONS OF THE TEXAS INSURANCE CODE AND ANTITRUST LAWS

Tex. Ins. Code Ann. art. 3.42 (Supp. 1977):

Policy Form Approval

(a) No policy, contract or certificate of life, term or endowment insurance, group life or term insurance, industrial life insurance, accident or health insurance, group accident or health insurance, hospitalization insurance, group hospitalization insurance, medical or surgical insurance, group medical or surgical insurance, or fraternal benefit insurance, and no annuity or pure endowment contract of group annuity contract, shall be delivered, issued or used in this by a life, accident, health or casualty insurance company, a mutual life insurance company, mutual insurance company other than life,

mutual or natural premium life insurance company, general casualty company, Lloyds, reciprocal or inter-insurance exchange, fraternal benefit society, group hospitalization service or any other insurer, unless the form of said policy, contract or certificate has been filed with the state Board of Insurance and approved by said Board as provided in Paragraph (c) of this Article.

. . .

* * * *

(c) Every such filing hereby required shall be made not less than thirty days in advance of any such issuance, delivery or use. At the expiration of thirty days the form so filed shall be deemed approved by the State Board of Insurance unless prior thereto it has been affirmatively approved or disapproved by the written order of said Board. The State Board of Insurance may extend by not more than an additional thirty days the period within which it may so affirmatively approve or disapprove any such form, by giving notice of such extension before expiration of the initial fifteen day period and at the expiration of any such extended period, and in the absence of such prior affirmative approval or disapproval, any such form shall be deemed approved. The Board of Insurance Commissioners may withdraw any such approval at any time. Approval of any such form by such Board shall constitute a waiver of any unexpired portion of the waiting period, or periods, herein provided.

(d) The order of the State Board of Insurance disapproving any such form or withdrawing a previous approval shall state the grounds for such disapproval or withdrawal.

(e) The State Board of Insurance may, by written order, exempt from the requirements of this Article for so long as it deems proper, any insurance document or form specified in such order, to which in its opinion this

Article may not practicably be applied, or the filing and approval of which are, in its opinion, not desirable or necessary for the protection of the public.

(f) The State Board of Insurance shall forthwith disapprove any such form, or withdraw any previous approval thereto if, and only if,

(1) It is in any respect in violation of or does not comply with this Code.

(2) It contains provisions which encourage misrepresentation or are unjust, unfair, inequitable, misleading, or deceptive or contrary to law or to the public policy of this state.

(3) It has any title, heading or other indication of its provisions which is misleading.

* * * *

Tex. Ins. Code Ann. art. 21.21 (1963 and Supp. 1977):

Unfair Competition and Unfair Practices

Sec. 1. *Declaration of Purpose.*—The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1946 (Public Law 15, 79th Congress),[1] by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

Sec. 2. *Definitions.*—When used in this Act:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyds insurer, fraternal benefit society, and any

[1] 15 U.S.C.A. §§ 1011-1015.

other legal entity engaged in the business of insurance, including agents, brokers, adjusters and life insurance counselors.

(b) "Board" shall mean the Board of Insurance Commissioners of this state.

Sec. 3. *Unfair Methods of Competition or Unfair and Deceptive Act or Practices Prohibited.*—No person shall engage in this state in any trade practice which is defined in this Act as, or determined pursuant to this Act to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

Sec. 4. *Unfair Methods of Competition and Unfair or Deceptive Acts or Practices Defined.*—The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(1) Misrepresentations and False Advertising of Policy Contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby or the dividends or share of the surplus to be received thereon, or making any false or misleading statements as to the dividends or share of surplus previously paid on similar policies, or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates, or using any name or title of any policy or class of policies misrepresenting the true nature thereof, or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance;

(2) False Information and Advertising Generally. Making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing any assertion, representation or statement with respect to the business of insurance or with respect to any person in the conduct of his insurance business, which is untrue, deceptive or misleading;

(3) Defamation. Making, publishing, disseminating, or circulating, directly or indirectly, or aiding or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature which is false, or maliciously critical of or derogatory to the financial condition of any insurer, and which is calculated to injure any person engaged in the business of insurance;

(4) Boycott, Coercion and Intimidation. Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance;

(5) False Financial Statements. . . .

(6) Stock Operations and Advisory Board Contracts. . . .

(7) Unfair Discrimination.

* * * *

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract

of accident or health insurance or in the benefits payable thereunder, or in any of the terms of conditions of such contract, or in any other manner whatever;

(8) Rebates. . . .

Sec. 5. *Power of Board.*—The Board shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair or deceptive act or practice prohibited by Section 3 of this Act.

Sec. 6. *Hearings, Witnesses, Appearances, Production of Books and Service of Process.*—(a) Whenever the Board shall have reason to believe that any such person has been engaged or is engaging in this state in any unfair method of competition or any unfair or deceptive act or practice defined in Section 4, and that a proceeding by it in respect thereto would be to the interest of the public, it shall issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than five days after the date of the service thereof;

(b) At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the Board requiring such person to cease and desist from the acts, methods or practices so complained of. Upon good cause shown, the Board shall permit any person to intervene, appear and be heard at such hearing by counsel or in person;

(c) Nothing contained in this Act shall require the observance at any such hearing of formal rules of pleading or evidence;

(d) The Board, upon hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which it deems relevant to the inquiry. The Board, upon such hearing, may, and upon the request of any party, shall cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the Board shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the District Court of Travis County or the county where such party resides, on application of the Board, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof;

* * * *

Sec. 7. *Cease and Desist Orders.*—(a) If, after such hearing under the terms of Section 6 of the Act, the Board shall determine that the method of competition or the act or practice in question is defined in Section 4 of this Article, or rules or regulations issued under this Article, or in Section 1746 of the Business & Commerce Code, as amended, and that the person complained of has engaged in such method of competition, act or practice in violation of this Article or rules and regulations issued under this Article or of the Deceptive Trade Practices—Consumer Protection Act (Sections 17.41 et seq., Business & Commerce Code), as specified in Section 17.46 of the Business & Commerce Code, it shall reduce its findings to writing and issue and cause to be served upon the

person charged with the violation an order requiring such person to cease and desist from engaging in such method of competition, act or practice.

* * * *

(c) Any person who violates the terms of a cease and desist order under this section shall be given notice to appear and show cause, at a hearing to be held in conformity with Section 6 of this Article, why he should not forfeit and pay to the state a civil penalty of not more than $1,000 per violation and not to exceed a total of $5,000. In determining whether or not a cease and desist order has been violated, the Board shall take into consideration the maintenance of procedures reasonably adapted to insure compliance with the order.

(d) An order of the Board awarding civil penalties under Subsection (c) of this section applies only to violations of this order incurred prior to the awarding of the penalty order.

* * * *

Sec. 10. *Penalty.*—Any person who violates a cease and desist order of the Board under Section 7, while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of Texas a sum not to exceed Fifty Dollars ($50.00), which may be recovered in a civil action, except that if such violation is found to be willful, the amount of such penalty shall be a sum not to exceed Five Hundred Dollars ($500.00).

Sec. 11. *Provisions of Act Additional To Existing Law.*—The powers vested in the Board by this Act shall be additional to any other powers to enforce any penalties, fines or forfeitures authorized by law with respect to the methods, acts and practices hereby declared to be unfair or deceptive.

* * * *

Sec. 13. *Rules and Regulations.*—(a) The State Board of Insurance is authorized to promulgate and may promulgate and enforce reasonable rules and regulations and may order such provision as is necessary in the accomplishment of the purposes of this Article and Article 21.20, including, but not limited to, such express provision within the purposes of these Articles as it deems necessary or as is required to affect necessary uniformity with the laws of other states or the United States or in conformity with the adopted procedures of the National Association of Insurance Commissioners notwithstanding any previous definition or interpretation of terms and used in these Articles had in or derived from the common law or other statutory law of this state.

* * * *

Sec. 14. *Administrative Class Action.*—(a) In connection with the issuance of a cease and desist order as provided in Section 7 of this Article or upon application of any aggrieved person, the Board may, after notice and hearing as provided in Section 6 of this Article, in connection with the issuance of a cease and desist order resulting from a finding that an insurer has engaged in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article, or Section 17.46, Business & Commerce Code, as amended, or upon finding by the Board that the aggrieved person and persons similarly situated were induced to purchase a policy of insurance as a result of the insurer engaging in a method of competition, act or practice in violation of this Article, rules or regulations issued under this Article or Section 17.46, Business & Commerce Code, as amended, the Board may require the insurer to account for all premiums collected for policies issued during the immediately preceding two years in connection with such acts in violation of this Article and require: (i) such insurer to give notice to all persons from whom

such premiums were collected, and (ii) to refund the total of all premiums collected from each such person, electing to accept a premium refund in exchange for cancellation of the policy of insurance issued. Premiums so refunded shall be net of policy benefits actually paid by such insurer while the policy of insurance was in force. The Board shall specify a reasonable time within which the insurer shall be required to make such premium refunds.

(b) If an insurer fails to comply with the Board's requirement to refund such premiums within the time specified, the Board may, in addition to any other sanctions provided for in the Insurance Code and other applicable laws, report such failure to the Attorney General and request the Attorney General to file a suit to enforce the Board's requirement for refund of premiums. Venue for such suit shall lie in the District Court of Travis County, Texas, and upon finding by the court that such requirement of the Board was lawfully entered and that the insurer has failed to comply with such requirement, the Court shall enter an appropriate order to enforce such Board order. The Court may enforce its order through contempt proceedings.

* * * *

Sec. 15. *Injunctions.*—(a) If the Board has reason to believe that any person in the insurance business in this state is engaging in, has engaged in, or is about to engage in any act or practice declared to be unlawful by this Article or rules or regulations issued under this Article or by Section 17.46 of the Business & Commerce Code, as amended, and that proceedings would be in the public interest, the Board may request the Attorney General to bring an action in the name of the state against the person to restrain by temporary or permanent injunction the use of such method, act, or practice.

* * * *

(c) In addition to the request for a temporary or permanent injunction in a proceeding brought under Subsection (a) of this section, the Attorney General, on a finding by the court that the defendant has engaged or is engaging in a practice declared to be unlawful by Article 17.46 of the Business & Commerce Code, as amended, this Article, or rules or regulations issued under this Article, may request a civil penalty of not more than $2,000 per violation and not to exceed a total of $10,000 to be paid to the state.

(d) The court may make such additional orders or judgments as are necessary to compensate identifiable persons for actual damages or restoration of money or property, real or personal, which may have been acquired by means of any act or practice restrained. Damages may not include any damages incurred beyond a point two years prior to the institution of the action.

(e) Any person who violates the terms of an injunction under this section shall forfeit and pay to the state a civil penalty of not more than $10,000 per violation not to exceed $50,000. In determining whether or not an injunction has been violated the court shall take into consideration the maintenance of procedures reasonably adapted to insure compliance with the injunction. For the purposes of this section, the district court issuing the injunction shall retain jurisdiction, and the cause shall be continued, and in such cases, the Attorney General with prior notice to the Board, acting in the name of the state, may petition for recovery of civil penalties under this section.

* * * *

Sec. 16. *Relief Available to Injured Parties.*—(a) Any person who has been injured by another's engaging in any of the practices declared in Section 4 of this Article to be unfair methods of competition and unfair and deceptive acts or practices in the business of in-

surance or in any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice may maintain an action against the company or companies engaging in such acts or practices.

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) three times the amount of actual damages plus court costs and attorneys' fees reasonable in relation to the amount of work expended;

(2) an order enjoining such acts or failure to act;

(3) any other relief which the court deems proper.

(c) On a finding by the court that an action under this section was groundless and brought in bad faith or for the purpose of harassment, the court may award to the defendant reasonable attorneys' fees in relation to the amount of work expended.

(d) In an action under this section, damages may not include any damages incurred beyond a point two years prior to the institution of the action.

Sec. 17. *Class Actions.*—(a) If a member of the insurance buying public has been damaged by an unlawful method, act, or practice defined in Section 4 of this Article or by the rules and regulations lawfully adopted by the Board under this Article or by any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice, the Board may request the Attorney General to bring a class action, or the individual damaged may bring an action on behalf of himself and others similarly situated, to recover damages and relief as provided in this section.

(b) A plaintiff who prevails in a class action under this section may recover:

(1) court costs and attorneys' fees reasonable in relation to the amount of work expended in addition to actual damages;

(2) an order enjoining the act or failure to act;

(3) any other relief which the court deems proper.

(c) On a finding by the court that an action under this section was brought by an individual plaintiff in bad faith or for the purpose of harassment, the court may award to the defendant reasonable attorneys' fees in relation to the work expended and court costs.

(d) In an action under this section, damages may not include any damages incurred beyond a point two years prior to the institution of the action.

(e) An action under this section may not be maintained if an administrative class action under Section 14 of this Article has been initiated or has resulted in a final determination regarding the same acts or practices and the same defendant in the action under this section.

* * * *

Tex. Bus. & Comm. Code Ann. § 15.02 (1963)

Trust Defined

(a) In this section, unless the context requires a different definition "person" does not include municipal corporation.

(b) A "trust" is a combination of capital, skill, or acts by two or more persons to

(1) restrict, or tend to restrict, trade, commerce, the preparation of tangible personal property for market or transportation, or the free pursuit of a lawful business; or

(2) fix, maintain, increase, or reduce the price of tangible personal property, the cost of in-

surance, or the cost of preparing tangible personal property for market or transportation; or

(3) prevent or lessen competition in

(A) the manufacture, transportation, sale, or purchase of tangible personal property;

(B) the business of insurance;

(C) aids to commerce; or

(D) preparing tangible personal property for market or transportation; or

(4) affect, control, or establish the price of tangible personal property, or the cost of transportation, insurance, or preparing tangible personal property for market or transportation; or

(5) agree

(A) not to sell, dispose of, transport, or prepare tangible personal property for market or transportation, or not to make an insurance contract, at a price below a common standard or figure;

(B) to maintain the price of tangible personal property, the charge for transportation or insurance, or the cost of preparing tangible personal property for market or transportation at a fixed or graded figure;

(C) to affect or maintain the price of tangible personal property or the cost of transportation, insurance, or preparing tangible personal property for market or transportation in order to preclude

free competition between or among themselves or others in the sale or transportation of tangible personal property, in the business of transportation or insurance, or in preparing tangible personal property for market or transportation; or

(D) to pool, combine, or unite an interest they have in the sale or purchase of tangible personal property, or in the charge for transportation, insurance, or preparing tangible personal property for market or transportation, so that the price of the tangible personal property, or charge for transportation, insurance, or preparing tangible personal property for market or transportation, might be in any manner affected; or

(6) regulate, fix, or limit the output of tangible personal property, or the amount of insurance undertaken, or the amount of work performed in preparing tangible personal property for market or transportation; or

(7) refrain from engaging in business, or from buying or selling tangible personal property, partially or entirely in this state.

Tex. Bus. & Comm. Code. Ann. § 15.04 (1963)

Monopoly, Trust, and Conspiracy in Restraint of Trade Prohibited; Agreement Violating Prohibition Void

(a) Every monopoly, trust, and conspiracy in restraint of trade, as defined in Sections 15.01, 15.02, and 15.03 of this code, respectively, is illegal and prohibited.

(b) An agreement violating the prohibition against a monopoly, trust, or conspiracy in restraint of trade contained in Subsection (a) of this section is void and unenforceable in law or equity.

Tex. Bus. & Comm. Code Ann. § 15.29 (1963)

Charter of Domestic Corporation Forfeited

(a) When he believes the public interest requires it, the attorney general shall file suit to forfeit the charter or articles of incorporation of a domestic corporation which has violated or is violating the prohibition contained in Section 15.04 of this code. The attorney general may file suit under this subsection in a district court in any county in the state.

Tex. Bus. & Comm. Code Ann. § 15.32 (1963)

Monetary Penalty

(a) A person adjudged guilty of violating the prohibition contained in Section 15.04 of this code shall pay a fine to the state of not less than $50 nor more than $1,500 for each day of violation. The attorney general, or a district, criminal district, or county attorney acting under his direction, shall represent the state in a suit filed to collect this fine.

Tex. Bus. & Comm. Code Ann. § 15.33 (1963)

Criminal Penalties

(a) A person may not agree to form, form, be a party to the formation of, or aid a monopoly, trust, or conspiracy in restraint of trade, as defined in Sections 15.01, 15.02, and 15.03(a)(1)-(3) of this code, respectively.